# I. Ovarian Cysts

# A. Management

- 1. Clients diagnosed with an ovarian cyst may be followed in the Family Planning clinic setting through two (2) menstrual cycles, unless any of the following are present, indicating a need for referral:
  - a. Pregnancy ectopic or intrauterine cannot be ruled out.
  - b. Cyst is bilateral, symptomatic and/or greater than 6 cm. in diameter.
  - c. Infection cannot be ruled out.
- 2. Clients currently taking oral contraceptives or Depo-Provera should be rechecked in one month, but may opt to continue their method at the discretion of the practitioner. If the cyst is still present at the recheck, then the client must be referred.
- 3. Patient may be followed for two (2) menstrual cycles per above criteria or put on a low-dose combination monophasic oral contraceptive (which will prevent new cyst formations) for two (2) cycles, providing:
  - a. Patient has no contraindications to oral contraceptives.
  - b. There is documentation of patient education regarding OCPs and method consent is signed.

### B. Education and follow-up

- 1. Document patient education regarding cyst and required follow-up.
- 2. Refer for evaluation if the cyst has not resolved after two (2) menstrual cycles or if any of the above criteria are met.
- 3. Follow-up contact should be made with the patient per Title X guidelines.

# II. Dysmenorrhea

## A. Primary dysmenorrhea

- 1. Management
  - a. Rule out secondary dysmenorrhea by exam, history, and lab.
  - b. Give combined or progestin-only oral contraceptives.
  - c. Recommend over-the-counter NSAID'S if no contraindication.

### B. Secondary dysmenorrhea

 Management - Identify the cause and treat per protocols or refer patient for MD evaluation.

- 2. Education and follow-up
  - a. Document patient education about dysmenorrhea.
  - b. Refer for MD evaluation if symptoms persist.

# III. Endocervical Polyps

- A. Management
  - 1. Patient should be referred for evaluation and possible removal.
  - 2. Removal may be done by skilled practitioner.
    - a. The specimen must be submitted to the lab for histopathologic examination.
    - b. If the patient is pregnant or the polyp is broad-based and does not clearly originate in the endocervical canal the patient must be referred for evaluation.
- B. Education and follow-up
  - 1. Education should be documented.
  - 2. Follow up as appropriate.

# IV. Endometriosis (previously diagnosed or suspected)

- A. Management
  - Diagnosis and treatment of endometriosis is beyond the scope of practice of most delegate agency sites. Clients suspected of having endometriosis may be referred for MD evaluation.
  - 2. Clients with a history of endometriosis may consider **continuous/extended cycling** of combined oral contraceptives (no placebo break) or DMPA if birth control is desired and there are no contraindications.
- B. Education and follow-up
  - 1. Document patient education.
  - 2. Follow-up as appropriate.

## V. Polycystic Ovarian Syndrome (PCOS)

- A. Management
  - If PCOS has not been diagnosed, patients with symptoms should be referred for evaluation and informed of their higher risk of infertility, diabetes, osteoporosis, and endometrial cancer
  - 2. Clients diagnosed with polycystic ovarian syndrome who request contraception can be given combined **hormonal** contraceptives, or DMPA.

- B. Education and follow-up
  - 1. Document patient education.
  - 2. Refer for evaluation as indicated above.

## VI. Amenorrhea

- A. Primary amenorrhea absence of menarche by either:
  - 1. 16 years of age in the presence of secondary sex characteristics,

or

- 2. 14 years of age in the absence of secondary sex characteristics.
- B. Secondary amenorrhea cessation of menses for at least three (3) cycles or six (6) months, whichever is less, in the non-breast-feeding woman who had previously established menses.
- C. Management
  - 1. Clients with primary amenorrhea must be referred for MD consultation.
  - 2. Clients with secondary amenorrhea:
    - Obtain a pregnancy test.
    - b. If the test is negative, and the client has not had unprotected intercourse in the last 10 days, the client may be started on combined hormonal contraceptives or given Provera 10 mg po qd for 5 days. However, progestin challenge may not be effective in women post DMPA or in women with inadequate estrogen priming of the endometrium.
      - (1) Women given combined hormonal contraceptives must be advised to use a back-up method for 2 weeks.
      - (2) Women taking Provera should be advised that withdrawal bleeding should ensue within 7-14 days after completion of the medication. Clients should be referred for MD evaluation if no bleeding occurs.

## VII. Premenstrual Syndrome (PMS)

- A. Management
  - 1. History and physical exam.
  - 2. Client education and support.
    - a. Diet high in complex carbohydrates and moderate protein, low in refined sugar and salt. Eat regular, small meals. Reduce/ eliminate: tea, coffee, caffeinated beverages, chocolate, alcohol and tobacco.
    - b. Aerobic exercise 30 minutes, 3 to 4 times a week.

- c. Relaxation response techniques.
- d. NSAIDs to treat specific symptoms.
- e. Vitamin B complex supplements no proven effect.
- f. FDA indications for use of SSRI
- 3. Education and follow-up

Clients who have severe symptoms of PMS and those who do not have symptom-free intervals should be referred for MD evaluation.

4. Subset of symptoms, called Premenstrual Dysphoric Disorder (PMDD)

PMDD focuses on the affective symptoms of PMS, and are defined by the American Psychiatry Association

B. Document patient education

# VIII. Uterine Leiomyomata (Fibroids)

- A. Management (previously diagnosed asymptomatic clients)
  - Clients may be followed in family planning clinic as long as the fibroids are ≤ 12 week size.
  - 2. Combined oral contraceptives are not contraindicated as long as the client is asymptomatic and the fibroids are <8 weeks size.
  - 3. Clients should be referred for MD evaluation if symptoms are present such as dyspareunia, urinary retention, frequency, pelvic pain or abnormal bleeding and other pathology cannot be ruled out, fibroids are >12 weeks size, or are enlarging.
- B. Education and follow-up
  - 1. Document patient education.
  - 2. Repeat pelvic exam at 3-6 months (at discretion of clinician) and annually.